30-10-17 (39) MS-2004

PROVIDER NUMBER

DECLARATION OF PREPARER:

I [illegible] COMPILED THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS PREPARED FOR _____ (PROVIDER NAME AND NUMBER) FOR THE COST REPORT PERIOD BEGINNING _____, 19_____, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION. THAT I HAVE REQUESTED ALL NECESSARY AND AVAILABLE MATERIAL AND THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

PREPARER'S SIGNATURE	TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

PREPARER'S ADDRESS (STREET, CITY, STATE, ZIP)	PHONE #
	( )

DECLARATION OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER:

I [illegible]Y CERTIFY THAT I HAVE READ THE ACCOMPANYING COST REPORT, INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS AND [illegible]O THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS TRUE, CORRECT, COMPLETE, AND IN AGREEMENT WITH RELATED BOOKS AND FEDERAL INCOME TAX RETURN EXCEPT AS EXPLAINED IN THE RECONCILIATION THAT ALL MATERIAL TRANSACTIONS WITH OWNERS OR OTHER RELATED PARTIES HAVE BEEN SUMMARIZED ON APPROPRIATE SCHEDULES. I CERTIFY THAT NO MATERIAL OR INFORMATION I HAVE ACCESS TO WOULD PRODUCE FINDINGS CONTRARY TO THOSE IN THE ACCOMPANYING COST REPORT INCLUDING ACCOMPANYING SCHEDULES AND STATEMENTS. I UNDERSTAND THAT THIS INFORMATION IS SUBMITTED FOR THE PURPOSE OF DEVELOPING PAYMENT RATES UNDER THE KANSAS MEDICAID PROGRAM. I UNDERSTAND THAT ANY FALSE CLAIMS, STATEMENTS OR DOCUMENTS, OR CONCEALMENT OF MATERIAL FACT MAY BE PROSECUTED UNDER APPLICABLE FEDERAL AND/OR STATE LAW.

SIGNATURE OF OWNER; PARTNER; OR OFFICER OF THE CORPORATION, CITY, OR COUNTY WHICH IS THE PROVIDER	

TITLE/POSITION	DATE

NAME (PRINT OR TYPE)

JUN 26 2001

TN#MS-94-02 Approval Date_____ Effective Date 1/1/94 Supersedes TN#MS-92-32

30-10-18 (1)

30-10-18. Rates of reimbursement. (a) Rates for existing nursing facilities.

(1) The determination of per diem rates shall be made, at least annually, on the basis of the cost information submitted by the provider and retained for cost auditing. The cost information for each provider shall be compared with other providers that are similar in size, scope of service and other relevant factors to determine the allowable per diem cost.

(2) Per diem rates shall be limited by cost centers and percentile maximums, except where there are special level of care facilities approved by the United States department of health and human services.

(A) The cost centers and percentile limits shall be as follows:

(i) Administration - 75th percentile;

(ii) property - 85th percentile;

(iii) room and board - 90th percentile; and

(iv) health care - 90th percentile.

(B) The property cost center maximum shall consist of the plant operating costs and an adjustment for the real and personal property fees.

(C) The percentile limits shall be determined from an annual array of the most recent historical costs of each provider in the data base.

(3) To establish a per diem rate for each provider, a factor for incentive, historical inflation, and estimated inflation shall

30-10-18 (2)

be added to the allowable per diem cost.

(4) Resident days in the rate computation.

(A) Each provider which has been in operation for 12 months or longer and has an occupancy rate of less than 85 percent for the cost report period shall have the resident days calculated at the minimum occupancy of 85 percent.

(B) The 85 percent minimum occupancy rule shall be applied to the resident days and costs reported for the 13th month of operation and after. The 85 percent minimum occupancy requirement shall be applied to the interim rate of a new provider unless the provider is allowed to file a projected cost report.

(C) The minimum occupancy rate shall be determined by multiplying the total licensed beds by 85 percent. In order to participate in the medicaid/medikan program, each nursing facility provider shall obtain proper certification for all licensed beds.

(D) Each provider with an occupancy rate of 85 percent or greater shall have actual resident days for the cost report period used in the rate computation.

(5) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(6) The effective date of the rate for existing providers shall be in accordance with K.A.R. 30-10-19.

(7) Effective January 1, 1994, the case mix payment rate shall be phased in for dates of service through June 30, 1994.

30-10-18 (3)

(A) Each provider will receive 50 percent of the rate under the previous system and 50 percent of the rate under the case mix methodology.

(B) Under the case mix methodology, all features of the reimbursement system shall remain with the exception of the health care cost center. The allowance in the health care cost center shall be adjusted by the average case mix index for each facility and based on the resident assessment and classification.

(C) There shall be a "hold harmless" provision for each provider who experiences a rate reduction based on the case mix adjustment for the period from January 1 through June 30, 1994. The rate from the previous payment methodology shall continue if the case mix adjusted rate is less.

(D) Rates shall be adjusted quarterly by the average case mix index for each facility.

(E) Each provider shall be given a detailed listing of the computation of the rate determined for the provider's facility.

(8) Effective July 1, 1994, each provider shall receive rates based strictly on the case mix methodology.

(A) There shall be no "hold harmless" provision.

(B) New limits and rates shall be determined on the basis of cost information submitted by the provider and retained for cost auditing.

(C) Rates shall continue to be adjusted quarterly by the case mix index and applied to the health care cost center for each facility.

30-10-18 (4)

(D) Detailed computations of the rate for each facility shall be given.

(9) Effective January 1, 1994, resident assessments that cannot be classified shall be assigned the lowest case mix index.

(b) Comparable service rate limitations.

(1) For each nursing facility and nursing facility for mental health, the per diem rate for care shall not exceed the rate charged for the same type of service to residents not under the medicaid/ medikan program.

(2) The agency shall maintain a registry of private pay rates submitted by providers.

(A) Providers shall notify the agency by certified mail of any private pay rate change and the effective date of that change.

(B) The private pay rate registry shall be updated based on the notification from the providers.

(C) The registry shall become effective on the first day of the third month after the regulation is adopted. The providers shall have the same length of time to notify the agency of the provider's private pay rate or the registry shall reflect the last private pay rate on file.

(3) The average private pay rate for comparable services shall be included in the registry. The average private pay rate may consist of the following variables.

(A) A differential for a private room can be included in the average private pay rate when medicaid/medikan residents are placed

30-10-18 (5)

in a private room at no extra charge and the private room is not medically necessary.

(B) Extra charges for ancillaries, routine supplies and other items included in the medicaid/medikan rate or payment outside of the rate, such as oxygen, can be included in the average private pay rate.

(C) If a level of care system is used to determine the average private pay rate, it shall be based on the level of care that best characterizes the overall medicaid/medikan population in the facility. For example, if the overall medicaid/medikan characteristics reflect moderate care, the private pay rate shall be based on the moderate level of care for comparable services.

(4) The average private pay rate shall be based on what the provider reasonably expects to receive from the resident. If the private pay charges are consistently higher than what the provider receives from the residents for services, then the average private pay rate for comparable services shall be based on what is actually received from the residents.

(5) When providers are notified of the effective date of the medicaid/medikan rate, the following procedures shall be followed.

(A) If the private pay rate indicated on the agency register is lower, then the medicaid/medikan rate, beginning with its effective date, shall be lowered to the private pay rate reflected on the registry.

30-10-18 (6)

(B) Providers who subsequently notify the agency by certified mail of the private pay rate shall have the medicaid/medikan rate adjusted the first day of the month following the date of the certified letter.

(c) Rate for new construction or new facility to the program.

(1) The per diem rate for newly constructed nursing facilities or a new facility to the medicaid/medikan program shall be based on a projected cost report submitted in accordance with K.A.R. 30-10-17.

(2) No rate shall be paid until a nursing facility financial and statistical report is received and processed for a rate.

(d) Change of provider.

(1) The payment rate for the first 12 months of operation shall be based on the rate established from the historical cost data of the previous owner or provider. If the 85 percent minimum occupancy requirement was applied to the previous provider's rate, it shall also be applied to the new provider's rate.

(2) When the care of the residents may be at risk because the per diem rate of the previous provider is not sufficient for the new provider to provide care and services in conformity with applicable state and federal laws, regulations, and quality and safety standards, and the old provider's rate is less than the average statewide rate, the new provider may submit a request in writing to the agency to file a projected cost report. The provisions of this subparagraph shall not apply when capital

30-10-18 (7)

improvements, applicable to all providers, are required by new state or federal regulations.

(e) Per diem rate errors.

(1) When the per diem rate, whether based upon projected or historical cost data, is audited by the agency and found to contain an error, a direct cash settlement shall be required between the agency and the provider for the amount of money overpaid or underpaid. If a provider no longer operates a facility with an identified overpayment, the settlement shall be recouped from a facility owned or operated by the same provider or provider corporation unless other arrangements have been made to reimburse the agency. A net settlement may occur when a provider has more than one facility involved in settlements.

(2) The per diem rate for a provider may be increased or decreased as a result of a desk review or audit on the provider's cost reports. Written notice of this per diem rate change and of the audit findings shall be sent to the provider. Retroactive adjustment of the rate paid from a projected cost report shall apply to the same period of time covered by the projected rate.

(3) Each provider shall have 30 days from the date of the audit report cover letter to request an administrative review of an audit adjustment that results in an overpayment or underpayment. The request shall specify the finding or findings that the provider wishes to have reviewed.

30-10-18 (8)

(4) An interim settlement, based on a desk review of the historical cost report covering the projected cost report period, may be determined within 90 days after the provider is notified of the new rate determined from the cost report. The final settlement shall be based on the rate after an audit of the historical cost report.

(5) A new provider that is not allowed to submit a projected cost report for an interim rate shall not be entitled to a retroactive settlement for the first year of operation.

(f) Out-of-state providers. The rate for out-of-state providers certified to participate in the Kansas medicaid/medikan program shall be the rate approved by the agency. Out-of-state providers require prior authorization by the agency.

(g) Determination of the rate for nursing facility providers re-entering the medicaid program.

(1) The per diem rate for each provider re-entering the medicaid program shall be determined from:

(A) A projected cost report in those cases where the provider has not actively participated in the program by the submission of any current resident service billings to the program for 24 months or more; or

(B) the last historic cost report filed with the agency, if the provider has actively participated in the program during the most recent 24 months. The appropriate historic and estimated inflation factors shall be applied to the per diem rate determined in

30-10-18 (9)

accordance with this paragraph.

(2) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(A) of this subsection, a settlement shall be made in accordance with K.A.R. 30-10-18(e).

(3) Where the per diem rate for a provider re-entering the program is determined in accordance with paragraph (1)(B) of this subsection, a settlement shall be made only on those historic cost reports with fiscal years beginning after the date on which the provider re-entered the program. The effective date of this regulation shall be January 1, 1994. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1985; amended May 1, 1986; amended, T-87-29, Nov. 1, 1986; amended May 1, 1987; amended, T-89-5, Jan. 21, 1988; amended Sept. 26, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994.)

30-10-19 (1)

30-10-19. Rates; effective dates. (a) Effective date of per diem rates for on-going providers filing calendar year cost reports. The effective date of a new rate that is based on information and data in the nursing facility cost report for the calendar year shall be the following July 1st.

(b) Effective date of the per diem rate for a new provider operating on the rate from cost data of the previous provider.

(1) The effective date of the per diem rate for a new provider shall be the date of certification by the department of health and environment.

(2) The rate effective date of the first historical cost report filed in accordance with K.A.R. 30-10-17 shall be the first day of the month following the end of the cost reporting period. Any rates paid after the effective date of the rate based on the first historical cost report shall be adjusted to the new rate from the historical cost report.

(c) Effective date of the per diem rate for a new provider from a projected cost report.

(1) The effective date of the per diem rate from a projected cost report for a new provider, as set forth in subsections (c), (d), and (g) of K.A.R. 30-10-18, shall be the date of certification by the department of health and environment.

(2) The interim rate determined from the projected cost report filed by the provider shall be established with the fiscal agent by the first day of the third month after the receipt of a complete and

30-10-19 (2)

workable cost report.

(3) The effective date of the final rate, determined after an audit of the historical cost report filed for the projected cost report period, shall be the date of certification by the department of health and environment.

(4) The second effective date for a provider filing an historic cost report covering a projected cost report period shall be the first day of the month following the last day of the period covered by the report. This is the date that historic and estimated inflation factors are applied in determining prospective rates.

(d) Effective January 1, 1994, providers shall receive a new rate based on the case mix adjustment. Providers shall receive new rates quarterly based on changes in the average case mix for the facility from previously submitted assessments. The effective date of this regulation shall be January 1, 1994. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1985; amended May 1, 1987; amended May 1, 1988; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994.)

30-10-23a (1)

30-10-23a. Non-reimbursable costs. (a) Costs not related to resident care, as set forth in K.A.R. 30-10-1a, shall not be considered in computing reimbursable costs. In addition, the following expenses or costs shall not be allowed:

(1) Fees paid to non-working directors and the salaries of non-working officers;

(2) bad debts;

(3) donations and contributions;

(4) fund-raising expenses;

(5) taxes, as follows:

(A) Federal income and excess profit taxes, including any interest or penalties paid thereon;

(B) state or local income and excess profits taxes;

(C) taxes from which exemptions are available to the provider;

(D) taxes on property which is not used in providing covered services;

(E) taxes levied against any patient or resident and collected and remitted by the provider;

(F) self-employment taxes applicable to individual proprietors, partners, or members of a joint venture; and

(G) interest or penalties paid on federal and state payroll taxes;

(6) insurance premiums on lives of officers and owners;

(7) the imputed value of services rendered by non-paid workers and volunteers;

30-10-23a (2)

(8) utilization review;

(9) costs of social, fraternal, civic, and other organizations which concern themselves with activities unrelated to their members' professional or business activities;

(10) oxygen;

(11) vending machine and related supplies;

(12) board of director costs;

(13) resident personal purchases;

(14) barber and beauty shop expenses;

(15) advertising for patient utilization;

(16) public relations expenses;

(17) penalties, fines, and late charges;

(18) prescription drugs;

(19) items or services provided only to non-medicaid/medikan residents and reimbursed from third party payors;

(20) automobiles and related accessories in excess of $25.000.00. Buses and vans for resident transportation shall be reviewed for reasonableness and may exceed $25,000.00 in costs;

(21) provider or related party owned, leased or chartered airplanes and related expenses;

(22) therapeutic beds;

(23) bank overdraft charges or other penalties;

(24) personal expenses not directly related to the provision of long-term resident care in a nursing facility;

30-10-23a (3)

(25) management fees paid to a related organization that are not clearly derived from the actual cost of materials, supplies, or services provided directly to an individual nursing facility;

(26) business expenses not directly related to the care of residents in a long-term care facility. This includes business investment activities, stockholder and public relations activities, and farm and ranch operations; and

(27) legal and other costs associated with litigation between a provider and state or federal agencies, unless the litigation is decided in the provider's favor.

(b) Purchase discounts, allowances, and refunds shall be deducted from the cost of the items purchased. Refunds of prior years' expenses shall be deducted from the related expenses. The effective date of this regulation shall be January 1, 1994. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1985; amended May 1, 1988; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended July 1, 1991; amended Oct. 28, 1991; amended May 1, 1992; amended Nov. 2, 1992; amended Jan. 3, 1994.)

30-10-25. Real and personal property fee. (a) The agency shall determine a real and personal property fee in lieu of an allowable cost for ownership or lease expense, or both. The real and personal property fee shall equal the sum of the property allowance determined under subsection (b) and the property value factor determined under subsection (c). The fee shall be facility-specific and shall not change as a result of change of ownership or lease by providers on or after July 18, 1984. An inflation factor may be applied to the fee on an annual basis.

(b) (1) The property allowance shall include an appropriate component for:

(A) Rent or lease expense;

(B) interest expense on real estate mortgage;

(C) amortization of leasehold improvements; and

(D) depreciation on buildings and equipment, calculated pursuant to subsection (d).

(2) The property allowance shall be subject to a program maximum. Percentile limitations shall be established, based on an array of the costs on file with the agency as of July 18, 1984.

(c) The property value factor shall be computed as follows.

(1) The sum of the components under paragraph (b)(1) shall be determined for each facility, based on costs on file with the agency as of July 18, 1984. These sums shall be placed in an array, and percentile groupings shall be developed from that array.

30-10-25 (2)

(2) The average property allowance shall be determined for each percentile grouping under paragraph (1).

(3) The average property allowance for each percentile grouping shall be multiplied by a percentage as established by the secretary.

(d) (1) The depreciation component of the property allowance shall be:

(A) Identifiable and recorded in the provider's accounting records;

(B) based on the historical cost of the asset as established in this regulation; and

(C) prorated over the estimated useful life of the asset using the straight-line method.

(2) (A) Appropriate recording of depreciation shall include:

(i) Identification of the depreciable assets in use;

(ii) the assets' historical costs;

(iii) the method of depreciation;

(iv) the assets' estimated useful life; and

(v) the assets' accumulated depreciation.

(B) Gains and losses on the sale of depreciable personal property shall be reflected on the cost report at the time of such sale. Trading of depreciable property shall be recorded in accordance with the income tax method of accounting for the basis of property acquired. Under the income tax method, gains and losses arising from the trading of assets are not recognized in the year of trade but are used to adjust the basis of the newly acquired property.

30-10-25 (3)

(3) For depreciation purposes, the cost basis for a facility acquired after July 17, 1984 shall be the lesser of the acquisition cost to the holder of record on that date, or the purchase price of the asset. The cost basis shall not include costs attributable to the negotiation or final purchase of the facility, including legal fees, accounting fees, travel costs and the cost of feasibility studies.

(e) (1) Providers may request a property fee rebasing if the following capital expenditure thresholds are met for related equipment or projects, or both:

(A) $25,000.00 for facilities with 50 or fewer beds; or

(B) $50,000.00 for facilities with 51 or more beds.

(2) The per diem from the interest or depreciation, or both, from the capital expenditures, reported in the ownership cost center of the cost report, shall be added to the property allowance per diem originally established. Interest expense reported in the administrative cost center of the cost report shall not be included in the rebasing request.

(3) Resident days used in the denominator of the property allowance calculation shall be based on the total resident days used to compute the rate being paid at the time the property rebasing is requested. The resident days shall be subject to the 85 percent minimum occupancy requirement, including new beds documented in the rebasing request.

30-10-25 (4)

(4) The revised property allowance shall be used to determine the property value factor. The revised property value factor shall be based on the existing arrays. The skilled nursing facility array shall be used for medicare skilled nursing facilities. The nursing facility array shall be used for all other facilities.

(5) Effective dates for rebased property fees:

(A) If new beds are added to a facility because of a construction project, the rebased property fee shall be effective on the date that the beds are certified by the department of health and environment.

(B) If the capital expenditure being rebased is not related to a bed size increase, the effective date of the rebased property fee shall be the first day of the month closest to the date upon which complete documentation has been received by the agency. Documentation includes:

(i) The depreciation schedule reflecting the expense;

(ii) the loan agreement;

(iii) the amortization schedule for interest;

(iv) invoices;

(v) contractor fees; and

(vi) proof of other costs associated with the capital expenditure.

(6) A property fee rebasing shall not be allowed if the request and documentation are submitted more than one year after the property subject to the rebasing has been acquired and put into

30-10-25 (5)

service. The effective date of this regulation shall be January 1, 1994. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1985; amended May 1, 1988; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Oct. 28, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994.)

30-10-28 (1)

30-10-28. Resident days. (a) Calculation of resident days.

(1) Resident day shall have the meaning set forth in K.A.R. 30-10-1a.

(2) If both admission and discharge occur on the same day, that day shall be considered to be a day of admission and shall count as one resident day.

(3) If the provider does not make refunds on behalf of a resident for unused days in case of death or discharge, and if the bed is available and actually used by another resident, these unused days shall not be counted as a resident day.

(4) Any bed days paid for by the resident, or any other party on behalf of the resident, before an admission date shall not be counted as a resident day.

(5) The total resident days for the cost report period shall be precise and documented; an estimate of the days of care provided shall not be acceptable.

(6) In order to facilitate accurate and uniform reporting of resident days, the accumulated method format set forth in forms prescribed by the secretary shall be used for all residents. These forms shall be submitted to the agency as supportive documentation for the resident days shown on the cost report forms and shall be submitted at the time the cost report forms are submitted to the agency. Each provider shall keep these monthly records for each resident, whether a medicaid/medikan recipient or a non-recipient. If the provider fails to keep accurate records of inpatient days in

30-10-28 (2)

accordance with the accumulated method format, the assumed occupancy rate shall be 100 percent.

(7) The provider shall report the total number of medicaid/ medikan resident days in addition to the total resident days on the uniform cost report form.

(b) Respite care days shall be counted as resident days and reported on the monthly census forms.

(c) Day care and day treatment shall be counted as one resident day for 18 hours of service. The total hours of service provided for all residents during the cost reporting year shall be divided by 18 hours to convert to resident days. The effective date of this regulation shall be January 1, 1994. (Authorized by and implementing K.S.A. 1992 Supp. 39-708c; effective May 1, 1985; amended May 1, 1987; amended Jan. 2, 1989; amended Jan. 2, 1990; amended, T-30-10-1-90, Oct. 1, 1990; amended Jan. 30, 1991; amended Nov. 2, 1992; amended Jan. 3, 1994.)

Methods and Standards for Establishing Payment Rates
Skilled Nursing and Intermediate Care Facility Rates
(NF's and NF's-MH)

Narrative Explanation of Nursing Facility Reimbursement Formula

The narrative explanation of the nursing facility (NF) and NF-Mental Health (NF-MH) reimbursement formula is divided into nine sections. The sections are: Cost Reports, Rate Determination, Retroactive Rate Adjustments, Case Mix Payment System, Reimbursement Limitations, Real and Personal Property Fee, Incentive Factor, Inflation Factors and Rate Effective Date.

COST REPORTS

The Nursing Facility Financial and Statistical Report (MS 2004) is the uniform cost report. It is included in Exhibit A-5. It organizes the commonly incurred business expenses of providers into four reimbursable cost centers (administration, plant operating, room and board, and health care). Ownership costs (i.e. mortgage interest, depreciation, lease and amortization of leasehold improvements) are reported but reimbursed through the real and personal property fee. There is a non-reimbursable/non-resident related cost center so that total operating expenses can be reconciled to the providers accounting records.

All cost reports are desk reviewed by agency auditors. Adjustments are made, when necessary, to the reported costs in arriving at the allowable historic costs for the rate computations.

Calendar Year End Cost Reports: All providers not a on projected rate or in the first year of operation are required to file the uniform cost report on a calendar year basis. The requirements for filing the calendar year cost report are found in Exhibit A-5.

When a non arms length change of provider takes place or an owner of the real estate assumes the operations from a lessee, the facility will be treated as an on-going operation. In this situation, the related provider or owner shall be required to file the calendar year end cost report. The new operator or owner is responsible for obtaining the cost report information from the prior operator

Methods and Standards for Establishing Payment Rates
Skilled Nursing and Intermediate Care Facility Rates
(NF's and NF's-MH)

Narrative Explanation of Nursing Facility Reimbursement Formula

for the months during the calendar year in which the new operator was not involved in running the facility. The cost report information from the old and new operators shall be combined to prepare a 12 month calendar year end cost report.

Projected Cost Reports: The filing of projected cost reports are limited to: 1) Newly constructed facilities; 2) Existing facilities new to the program; 3) New providers when the rate of the previous provider places the residents care at risk and the rate is less than the statewide average; or 4) A provider re-entering the program who has not actively participated or billed services for 24 months or more. The requirements are found in Exhibit A-5. The projected cost report is desk reviewed by agency auditors. Rates from the projected cost reports are subject to upper payment limits.

Historical Cost Report Covering Projected Cost Report Period Or The First Year of Operation of a New Provider: The cost report requirements are found in Exhibit A-5.

RATE DETERMINATION

Medicaid rates for Kansas NFs and NFs-MH are determined using a prospective, facility-specific rate setting system. The rate is based on the costs from the latest cost report submitted by the provider. The rate is subject to upper payment limits established by the agency for the limitation period. Computer software has been developed and is used for calculating the facility specific payment rates.

The allowable expenses are divided into four centers in the cost report. The cost centers are Administration, Plant Operating, Room and Board and Health Care. An owner/administrator limitation is applied in determining the allowable cost. This limitation will be explained in detail in another section of this exhibit.

The allowable historic per diem cost is determined by dividing the allowable resident related expenses in each cost center by the greater of actual resident